Baltimore City Health Department
Oral Health Services
Registration/Medical History Form

Name_____ Today's Date _____

Date of Birth_____ Sex **(circle one)** Male Female Ethnicity/Race_____

Address _____Zip code_____

Best phone number to reach you:_____ Home /Work /Cell /Pager? **(circle one)**

Patient's Social Security Number:_____

Are you being referred to us? **YES** **NO** If **YES**, by whom? _____

Please answer **YES** or **NO** next to any of the medical condition(s) the patient has or ever had:

1. _____Heart Murmur
2. _____High Blood Pressure
3. _____Heart Problems/Conditions (not heart murmur)
4. _____Stroke
5. _____Hepatitis, Yellow Jaundice
6. _____Diabetes, "Sugar"
7. _____TB (Tuberculosis)
8. _____Asthma
9. _____Epilepsy, Seizures
10. _____Excessive bleeding
11. _____Fainting
12. _____Dizziness
13. _____Circulatory problems
14. _____Kidney disease
15. _____Sickle Cell (Disease/Trait)
16. _____Behavioral/Mental Problems
17. _____Liver Disease
18. _____Rheumatic fever/Scarlet fever
19. _____Bronchitis
20. _____Arthritis
21. _____Sinus problems
22. _____Venereal disease

Is the patient pregnant? (Circle one) **YES** **NO** **UNSURE** If **YES**, how many months?_____

Please answer **YES** or **NO** to the following questions:

_____ Has the patient ever tested POSITIVE for HIV? If **YES**, when? _____

_____ Has the patient ever had a blood transfusion? If **YES**, when? _____

_____ Has the patient ever used IV drugs, crack, cocaine or heroin? If **YES**, when? _____

_____ Does **PENICILLIN** cause any unusual reactions? (i.e., rash, swelling, unable to breathe)

_____ Are there any other medicine(s) that break the patient out or cause a problem for the patient?

If **YES**, please list:_____

_____ Has the patient ever been treated for **CANCER?**: If **YES**, what type & when?_____

_____ Vision/Hearing problem: (circle which) If **YES**, which ear or eye? Right Left Both

_____ Dental Problems: (check which ones) _____cavities _____bleeding gums _____ other:_____

Does the patient smoke? (Circle one) **YES** **NO** Does the patient drink alcohol? (Circle one) **YES** **NO**

Is the patient taking any prescribed medications or drugs? (Circle one) **YES** **NO**
If **YES**, please list all:_____

_____

Has the patient ever been hospitalized? (Circle one) **YES** **NO**
If **YES**, please list When & Why:_____

_____

Please list any medical treatment, impending operations or other handicapping conditions that may affect the dental treatment for the patient:_____

X_____

SIGNATURE (Patient or legal guardian, if patient under 18yrs. of age)

MEDICAL HISTORY UPDATE

1. Has there been any change in the patient's health since his/her last visit with us? **YES** **NO**
   If **YES**, please state change:_____

2. Has the patient been hospitalized for any reason since his/her last visit? **YES** **NO**
   If **YES**, please state reason & when it occurred:_____

   _____

3. Is the patient taking any new medication(s)? **YES** **NO**
   If **YES**, please list:_____

4. Does the patient smoke? (CIRCLE ONE) **YES** **NO**

_____ **X**_____
DATE **SIGNATURE (Patient or legal guardian, if patient under 18yrs. of age)**

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   If **YES**, please list:_____

4. Does the patient smoke? (CIRCLE ONE) **YES** **NO**

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